WiRO
WorkCover independent review office

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RECOMMENDATION FOLLOWING AN APPLICATION FOR REVIEW OF THE INSURER'S WORK CAPACITY DECISION PURSUANT TO SECTION 44(1)(c) OF THE *WORKERS COMPENSATION ACT* 1987.

1. The injured worker is the applicant for a review of a work capacity decision made by a self-insurer licensed to operate under the New South Wales workers compensation scheme ("Insurer").

2. The applicant suffered injury to her left shoulder on 15 April 2009 in the course of her employment with the Insurer as a supermarket register operator. There is no dispute about the injury having occurred in the course of employment.

3. The applicant continued to work on reduced duties for a further year until her employment was terminated in April 2010. She has not worked since. Liability was accepted by the Insurer and the applicant was paid for all relevant periods under section 40 of the *Workers Compensation Act* 1987 (1987 Act). The applicant was a continuing recipient of weekly payments of compensation immediately before 1 October 2012.

4. While the applicant was in receipt of weekly payments of workers compensation the Insurer wrote to her on 20 March 2013 purporting to confirm a conversation of the same date held in person at a Municipal Library (not premises controlled by the employer). The letter purported to give notice of an impending work capacity assessment, to be followed by a work capacity decision likely to result of a cessation of weekly benefits. The applicant was assured that all relevant information would be considered and the following two paragraphs set out the process to be followed:

> We confirm under the review process we will consider all relevant information that we currently have on file including medical report certificates (sic), return to work plans, workplace rehabilitation report. Part of the review process may also include further discussions with other parties such as your employer, nominated treating doctor or other treatment providers.

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5. By letter dated 16 April 2013 the Insurer advised the applicant in writing of the work capacity decision. She was advised as follows:

> You have no further entitlement to weekly benefits, pursuant to Section 38(3) of the *Workers Compensation Act* 1987.
>
> Pursuant to section 54 of the *Workers Compensation Act* 1987 as amended and clause 9(1) of Part 19H of Schedule 6 of the *Workers Compensation Act* 1987 an insurer is required to give 3 months' notice prior to reducing benefits as a result of a Work Capacity Decision.[1]
>
> The reduction in your weekly payments will therefore take effect from 23rd July 2013 provided that we have valid Certificates of Capacity to cover this period.[2]

6. On 16 May 2013 the Insurer received an application for Internal Review. On 14 July 2013 the Insurer wrote to the applicant advising that the internal reviewer had upheld the original decision.

7. A WorkCover Merit Review was completed and a Statement of Reasons issued on 27 August 2013. The Merit Reviewer upheld the original decision of the insurer. The Merit Reviewer found that the applicant has no entitlement to weekly benefits in accordance with section 38.

8. On a form dated 24 September 2013, the applicant requested the Independent Review Officer to undertake a review of the decision of the Insurer pursuant to Section 44(1)(c) of the 1987 Act. I am satisfied that the applicant has made that application within the time provided by that section and on the proper form. Underneath the heading "Authorisation for WIRO" the applicant requested and authorised WIRO to send a copy of the Application to the Insurer on her behalf.

The Applicant's Stated Grounds for Procedural Review

[1] This is incorrect on two grounds: first, the three months do not own the notice, as the possessive apostrophe would otherwise indicate, and secondly Schedule 6 Pt 19H Div 2 cl 9(1) of the 1987 Act says nothing about notice. It is only section 54 which is relevant.
[2] The Insurer thereby fully complied with the notice requirements in section 54.

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9. The applicant's grounds for pursuing procedural review are short. In full they may be quoted as follows:

> I would like a review of the unfavourable decision on my work capacity assessment.

Submissions by the Insurer

10. The Insurer produced thirteen numbered paragraphs of submissions in response to the application for procedural review filed by the applicant. They are largely based on the false premise that procedural review can only proceed if (a) the applicant personally serves the application for procedural review on the Insurer and (b) does so within 30 days of receipt of the Merit Review decision.

    Section 44(2) is in these terms:

> (2) An application for review of a work capacity decision must be made in the form approved by the Authority and **specify the grounds** on which the review is sought. The **worker must notify the insurer** in a form approved by the Authority of an application made by the worker for review by the Authority or the Independent Review Officer.

    True it is that section 44(2) says in part that the worker must notify the insurer in a form approved by the Authority of an application made by the worker for review by the Independent Review Officer, but the form approved by the Authority includes a provision for the worker to authorise and request the Independent Review Officer to serve the insurer on their behalf. There is no time limit for this service, since the 30 day limit only refers to the time by which the worker must make application to the Independent Review Officer. In this case the Independent Review Officer served the form on the Insurer. When serving the form the Independent Review Officer asked the Insurer to forward any submissions they wished to make within seven days, which the Insurer did.

11. The Insurer also alleges that the applicant has not specified "the grounds on which the review is sought," as required by section 44(2). Since section 44(2) covers both merit review and procedural review, "grounds"

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may mean no more than indicating that it is a *merit* review or a *procedural* review which is sought, something easily inferred from the form approved by the Authority. It would be an uncommon reading of the legislation which restricted unrepresented workers to relying only on specified grounds of procedural review adduced in the application form.

12. The Insurer ultimately submits that because of these allegedly incurable defects of service, notice and grounds, I should decline to review the application for procedural review altogether. The Insurer does so secure in the belief that they have "made the correct decision and complied with the procedural requirements" of the 1987 Act.[3]

The Legislative Framework

13. The legislative framework which governs the entitlement to and the transition from the previous benefits is complex and must be difficult for an injured worker without legal assistance to navigate through and to understand its impact. Set out shortly, there may be thought to be no less than four steps involved, all of them mandatory.

i. An insurer may make a work capacity assessment at any time (see section 44A(1)). Section 44A(3) also provides that an assessment is not necessary for the making of a work capacity decision.

ii. Section 43 provides that a work capacity decision may be made by an insurer and is binding on the parties, subject to review only under section 44 or by judicial review in the Supreme Court of NSW. Under *WorkCover Work Capacity Guidelines* published on 28 September 2012 (the version relevant for the purposes of the applicant's claim), *Guideline 5* states in part:

> "A work capacity decision is a discrete decision that may be made at any point in time and can be about any one of the factors described in section 43(1), such as the worker's capacity to earn in suitable employment. This is different to a work capacity assessment which is a review process that may

[3] For more on this, see below.

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> or may not lead to the making of a work capacity decision or another type of decision regarding a claim."

iii. In *Guideline 5.2* a "fair notice provision" sets out the information which must be communicated to a worker "at least two weeks prior to" the work capacity decision.[4] So far the Insurer would have had to make an *assessment*, or be in the process of making an *assessment*, and prior to the finalisation of that *assessment* and the subsequent making of a *decision*, "at least two weeks" notice must be given to the worker of the following matters:

- inform the worker that a review of their current work capacity is being undertaken and that a work capacity decision is going to be made;
- an explanation that this review may include further discussions with other parties such as their employer, nominated treating doctor or other treatment providers;
- advise the potential outcome of this review and detail the information that has led the insurer to their current position;
- provide an opportunity for the worker to supply any further information to the insurer for further consideration and the date that this information is to be provided by; and
- tell the worker when this decision is expected to be made.

This pentalogue of bullet points is prefaced with the following words (emphasis added):

> "...the insurer must ... communicate this to the worker in a way that is appropriate in the circumstances of the case, and *preferably by telephone* or in person."

In a workers compensation system where the overwhelming majority of claimants are manual workers with limited education, and a high percentage do not have English as a first language, it is surprising that it would be thought appropriate to try to communicate important and complex information concerning a workers livelihood over the telephone rather than in writing. Further, in the process of

[4] This of course means that a decision cannot be made "at any point in time," (*contra Guideline 5)* since it cannot be made until the fair notice period has elapsed.

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determining whether or not a worker has been afforded procedural fairness, it is impossible for a reviewer to know the adequacy or even the accuracy of any information communicated verbally to a worker by an insurer over the telephone.

iv. In the event of a decision resulting in a variation of the weekly benefits payable to a worker, section 54 requires that the worker be given at least 3 months notice of that proposed variation, which must be notice delivered either in person or by post. I should emphasize here that there is no statutory requirement for a "notice" to be given to a worker of a *decision* under section 43. The notice requirement in section 54 arises from a proposed variation in payments and therefore the issue of "notice" may not arise in circumstances where no variation in payments results from a work capacity decision.

14. The *Guidelines* which were gazetted on 28 September 2012 set out the necessary requirements of "a Work Capacity Decision Notice" at 5.4.2 thus:

> **5.4.2. Requirements of a Work Capacity Decision Notice**
>
> The **Work Capacity Decision Notice** must:
>
> • reference the relevant legislation
>
> • explain the relevant entitlement periods
>
> • state the decision and give brief reasons for making the decision
>
> • outline the evidence considered in making the decision, noting the author, the date and any key information. All evidence considered should be referred to, regardless of whether or not it supports the decision.
>
> • clearly explain the line of reasoning for the decision
>
> • state the impact of the decision on the worker in terms of their entitlement to weekly payments, entitlement to medical and related treatment expenses and return to work obligations
>
> • advise when the decision will take effect

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• detail any support, such as job seeking support, which will continue to be provided during the notice period

• advise that any documents or information that have not already been provided to the worker can be provided to the worker on request to the insurer

• advise of the process available for requesting review of the decision and how to access the required form, *Application for review of a work capacity decision by insurer*.

There is a great deal of ground covered in those ten points, which may lead to difficulties with compliance. A particular difficulty is caused by the subjunctive mood of the word "must" immediately prior to the first bullet point.[5] It would follow that a breach of even a single element of this decalogue similarly 'must' result in invalidity of the notice. This position is fortified by the status of the *Guidelines* as delegated legislation.

15. The *Guidelines* gazetted on 28 September 2012 also purport to set out the way a work capacity decision should be made. Relevantly, clause 5.1 is in these terms:

5.1. Making a work capacity decision

- When making a work capacity decision the insurer should follow the *Best Practice Decision-Making Guide*[6] including:

- ensuring that all reasonable opportunities to establish capacity for work have been provided to the worker

- ensuring that the insurer meets their responsibility of establishing and supporting an injury management plan tailored to the worker's injury as set out in Chapter 3 of the 1998 Act

- evaluating all available and relevant evidence

[5] "Must" also qualifies the pentalogue in *Guideline* 5.2.
[6] Presumably the insurer should do the best it can in the absence of that document existing.

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- following a robust and transparent decision-making process with clear, concise and understandable information provided to the worker giving reasons for decisions

- seeking any additional information that is required to ensure the worker's current capacity for work is fully understood

- providing opportunity for the worker to contribute additional information, especially if the decision may result in reduction or discontinuation of the worker's weekly payments

- ensuring decision makers have the appropriate expertise, ability, and support to make the decision they are making.

Any work capacity decision should be logical, rational and reasonable. It should be a decision that is more likely than not to be correct. In many cases the insurer will already have all the information they need to make a work capacity decision without the need to refer the worker for additional evaluations by third party service providers.

Process of the Insurer

16. The decision reached by the Insurer was within the range of available decisions, and was maintained by the Merit Review Service of the WorkCover Authority. However, such considerations are of no interest in the course of procedural review where the main relevant consideration is not why a decision is made, but *how* it is made.[7]

17. I am satisfied that the Insurer had regard to medical evidence, including at least one "certificate"[8] from the applicant's Nominated Treating Doctor. I am unaware of any other evidence considered by the Insurer, since the totality of the evidence referred to in the letter advising of the work capacity decision is listed as follows, under the heading "Evidence considered in making this decision":

[7] For a related discussion of the distinction see *Minister for Immigration and Citizenship v Li* (2013) 297 ALR 225 per Gageler, J at 253.
[8] There is either a WorkCover Medical Certificate or a Certificate of Capacity, or there may be one of each.

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- WorkCover Medical Certificate completed by Dr V

In the letter advising the applicant of the outcome of Internal Review, the totality of the evidence relied upon by the Insurer was listed under the same heading thus:

- WorkCover NSW – Certificate of Capacity

I have no idea whether these are the same document differently described or two different documents. In the first letter there is a reference to a "WorkCover Medical Certificate" prepared on an undisclosed date by the applicant's nominated treating doctor, and in the second letter there is a reference to a "Certificate of Capacity" of undisclosed authorship and undisclosed date. In the body of the second letter there is a passing reference near the top of page 3 to "... medical certificate of your nominated treating doctor, Dr dated 13 February 2013." The name of the doctor is actually missing. Lower down on the same page a further reference is made to what may well be the same document, described as "a medical certificate dated 13 February 2013" by the applicant's nominated treating doctor who is named. But on the very next page under the heading "Evidence considered in making this decision" all the Insurer lists is "WorkCover NSW – Certificate of Capacity." A WorkCover Medical Certificate is a very different document to a Certificate of Capacity.

This appears to be a breach[9] of the *Guidelines* which require an insurer to

> - outline the evidence considered in making the decision, noting **the author**, **the date** and any key information.[10]

While towards the bottom of page 3 of the second letter the Insurer extracts some content from a medical certificate of 13 February 2013 and attempts to show how this justifies their decision, no such attempt was made in the first letter.

My Reasons:

[9] More accurately, two breaches.
[10] See *Guideline* 5.4.2 – emphasis added.

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18. The applicant's only stated ground for seeking procedural review is that the work capacity decision following the assessment by the Insurer is "unfavourable." This is the basis on which the Insurer alleges that no proper grounds are set out. It is certainly the case that the applicant has particularised no breaches of the legislation, the *Guidelines* or the Regulation. This however is not fatal for the applicant, since nowhere in the *Guidelines* or the legislation does any provision appear requiring the applicant to enumerate specific grounds of procedural review, which would be a concept understood by lawyers but few others in the community. Section 44(2) covers both merit review and procedural review and it is my opinion that the applicant sufficiently complies with the "grounds" requirement in that section to specify that she seeks a review of the work capacity decision on procedural grounds, which she indicates by making application on the relevant form for procedural review. It is an unrealistic expectation to think that a non-lawyer would be familiar with the distinction to be drawn between broad *ultra vires* and narrow *ultra vires*, or the requirements for the rules of natural justice to be applied, as set down by Lord Reid in *Ridge v Baldwin.*[11]

    The haecceity distinguishing procedural review under section 44(1)(c) from other types of review is that the Independent Review Officer may have regard only to "the insurer's procedures in making the work capacity decision" and may not have any regard to "any judg[e]ment[12] or discretion exercised by the insurer in making the decision." It follows that no grounds need be set out by a complainant, since the Insurer either did or did not comply with the procedural requirements, something which is ascertainable irrespective of the opinion or submissions of an injured worker. It also follows that the submission in this case on behalf of the Insurer that the applicant has "made no complaint" concerning procedure is of no relevance and must fail.

19. The task for a procedural reviewer is to ensure that an insurer has complied with the relevant legislation, *Guidelines* and any rules of natural justice which may apply. The Insurer submits that it has "made the

[11] *Ridge v. Baldwin* (1963) 2 ALL E.R. 66; (1964) A.C. 40
[12] Misspelt in the Act as "judgment." Whereas a judgment is delivered by a court, judgement can be exercised by anyone.

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correct decision and complied with the procedural requirements" of the 1987 Act.

Contrary to this assertion, there are several errors of procedure which must result in invalidity for the reason that they constitute breaches of the *Guidelines* or the legislation or both.

- In the fair notice letter dated 20 March 2013 the Insurer told the applicant that they would "consider all relevant information ... currently on file including medical report certificates, return to work plans, workplace rehabilitation reports" and that as part of the review process further discussions might take place with other parties such as the employer, nominated treating doctor or other treatment providers. There is no evidence that any such discussions took place, and the only evidence relied upon by the Insurer seems to be one of either a medical certificate or a certificate of capacity, possibly prepared by the nominated treating doctor on either 13 February 2013 or an otherwise unspecified date.

- I am aware that in the course of merit review the Insurer produced additional documents at the request of the merit reviewer, having been asked to do so by the applicant. Here is a list of the documents produced on merit review as reproduced at paragraphs 17-20 of the merit review decision :

    - WorkCover NSW Medical certificates dated 2 August 2012, 10 September 2012, 13 September 2011, 9 December 2012 and 17 December 2012.

    - WorkCover NSW – certificate of capacity dated 13 February 2013.

    - Physiotherapy management plan dated 24 July 2012

    - Reports from Physio C dated 20 April 2012

    - Report from Dr M dated 20 April 2012

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- Exercise Physiology Management Plans dated 4 July 2012 and 4 March 2013
- Initial assessment report from P Rehabilitation dated 3 July 2012
- Proposed Gym-Based Program and Approval to Commence Services from P Rehabilitation dated 26 June 2012, 4 July 2012 and 4 March 2012
- Mid program report from P Rehabilitation dated 20 December 2012
- Final program report from P Rehabilitation dated 4 March 2013.
- Reports Dr T dated 13 February 2012, 1 November 2011 and 13 September 2011
- Report of Dr K dated 28 July 2009.

- In addition to the plethora of reports listed above, the merit review decision also contains references to a Medical Assessment Certificate issued by a Dr A dated 19 April 2011 and an otherwise undescribed report by a Dr Th, who was clearly no supporter of the applicant.

- The additional documents provided to the merit reviewer were nowhere referred to in the correspondence between the Insurer and the applicant. Even if the Insurer had the view that the documents were irrelevant[13] they had assured the applicant that they would consider all relevant documents on file including rehabilitation reports and return to work plans. There are two reports dated 4 March 2013 which could scarcely be thought too old and therefore irrelevant to a decision made on or about 16 April 2013.

[13] The Insurer made this submission to the merit reviewer concerning the relevance of several medical reports, alleging they were too old.

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- Accordingly the Insurer has breached *Guideline* 5.1 which requires an evaluation of "all available and relevant evidence."

- If the Insurer insists that it has complied with *Guideline* 5.1, then it must have breached *Guideline* 5.4.2 which requires an Insurer to

  > outline the evidence considered in making the decision, noting the author, the date and any key information. All evidence considered should be referred to, regardless of whether or not it supports the decision.

20. Under the legislation the Insurer can make an assessment of the applicant's work capacity and then a decision about that work capacity, but they must comply with the legislation, the Regulation and the *Guidelines* in order to produce a procedurally correct result. In the current instance there has been more than one breach of the *Guidelines* which are to be treated as delegated legislation. Accordingly the work capacity decision must be found to be invalid.

My Recommendation:

21. For the reasons set out above I recommend that the Insurer undertake another work capacity assessment and, if it arises, make another work capacity decision, according to the *Guidelines* as gazetted by the Authority and according to the relevant legislation.

22. Since the applicant was an existing recipient as at 1 October 2012, she remains entitled to receive her pre-transition rate of weekly benefits until such time as she is validly transitioned under the Act. This cannot happen until a valid notice under section 54 is issued. Accordingly she remains entitled to her former weekly payments until she is validly transitioned and a section 54 notice issues and the relevant period of notice therein has expired. Since the applicant is to be restored to her correct payments, rather than receiving an "increase" in benefits, clause 21 of Schedule 8 of the *Workers Compensation Regulation* 2010 cannot apply and no new notice period is required.

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23. Noting the binding nature of these recommendations[14] I recommend that the Insurer takes my views into account, and I recommend that the Insurer immediately gives effect to them.

Wayne Cooper
Delegate of the WorkCover Independent Review Officer
20 November 2013

[14] See section 44(3)(h) of the 1987 Act – recommendations made by the Independent Review Officer are binding on the insurer and the Authority.